

**MDR Tracking Number: M5-04-1769-01**

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 2-17-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visits, therapeutic exercises, therapeutic procedures, and physical performance test with report rendered from 2/17/03 through 5/22/03 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On August 12, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 19 days of the requestor's receipt of the Notice.

- **CPT Code 99080-73**--The carrier denied this code with a V for unnecessary medical treatment based on a peer review, however, the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter and, therefore, recommends reimbursement. In accordance with Rule 133.307 (g)(3)(A-F), the requester submitted relevant information to support delivery of service. **Reimbursement is recommended** for four dates of service from 2/21/03 through 5/22/03 for a total of \$60.00.
- **CPT Codes 99213, and 97530 for date of service 4/3/03**-- Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the recon HCFAs reflected proof of submission. Also, the requester submitted relevant information to support delivery of service. Therefore, the disputed service or services will be reviewed according to the 1996 Medical Fee Guidelines. **Reimbursement is recommended** in the amount of \$118.
- **CPT Code 97110 for date of service 4/3/03**- Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the

Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy.

**Additional reimbursement not recommended.**

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 2/21/03 through 5/22/03 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 30<sup>th</sup> day of September 2004.

Regina L. Cleave  
Medical Dispute Resolution Officer  
Medical Review Division

RLC/rlc

### **NOTICE OF INDEPENDENT REVIEW DECISION**

July 1, 2004

**Re: IRO Case # M5-04-1769**  
**IRO Certificate #4599**

Texas Worker's Compensation Commission:

\_\_\_ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule 133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, \_\_\_ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Orthopedic Surgery, and who has met the requirements for TWCC Approved Doctor List or has been approved as an

exception to the Approved Doctor List. He or she has signed a certification statement attesting

that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to \_\_\_\_ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the \_\_\_\_ reviewer who reviewed this case, based on the medical records provided, is as follows:

#### Medical Information Reviewed

1. Table of disputed service 2/27/03 – 7/8/03
2. Explanation of benefits
3. Pre op H&P 7/21/03
4. Operative report 9/11/02, 7/3/03
5. Clinic notes 9/20/02 – 8/15/03
6. Letter of appeal
7. Pain center notes 2/17/03 – 5/6/03
8. FCE 2/24/03

#### History

The patient suffered multiple injuries, including an injury to her right knee, in \_\_\_\_, when she fell to the floor. The patient underwent right knee arthroscopy with subtotal lateral meniscectomy, extensive chondroplasty of the lateral compartment of the knee, and chondroplasty of the patellofemoral and medial compartments of the knee. The patient was prescribed post operative physical therapy. She was evaluated by her surgeon on 9/20/02, 11/5/02 and 12/31/02. On each follow up visit the surgeon prescribed physical therapy. The last prescription, on 12/31/02 recommended therapy two times per week for eight weeks. The patient did not follow up with the surgeon again until 4/8/03, at which time the surgeon recommended proceeding with total knee arthroplasty, due to the failure of conservative treatment measures. The patient underwent multiple evaluations, physical therapeutic exercises and treatments, and a functional capacity evaluation between 2/17/03 and 5/6/03.

#### Requested Service(s)

Office outpatient visit E&M EST low-mod severity, therapeutic exercises, therapeutic procedure, physical performance test/measure with report, 2/17/03 – 5/22/03

#### Decision

I agree with the carrier's decision to deny the requested services.

#### Rationale

After the patient underwent surgery in September 2002, she received prescribed physical therapy for a period of five months. This amount of therapy is more than

adequate to rehabilitate the patient's knee after her arthroscopy. The patient was

obviously suffering from severe post-traumatic degenerative joint disease. Five

months after the right knee arthroscopy, the patient continued to suffer from significant symptoms of degenerative arthristis, which were not alleviated with physical therapeutic exercise and treatments. There was no indication for continuing treatment after completing the therapy prescribed by the surgeon on 12/31/02. After five months of outpatient therapy, the patient should have been able to continue a home exercise program for long term strengthening in preparation for a total knee replacement. In addition, the treatment notes from the pain center are vague, repetitive, and do not even indicate who is performing the evaluation.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.